S. No. 2
-11-10-39
5-17-39
I X21492

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

Rec'd APR 15 1940

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 9325

Registration District No. 791 Primary Registration District No. 1003 Registrar's No. 2808

1. PLACE OF DEATH:

(a) County St Louis
(b) City or town St. Louis Mo. (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Homer Phillips Hospt. (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 5 wks (Specify whether years, months or days) In this community abt 15 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State ____ (b) County ____
(c) City or town 21 (If outside city or town limits, write "RURAL")
(d) Street No. 2417 DICKSON AVE (If rural, give location)
(e) If foreign born, how long in U. S., if alien? ____ years.

8. (a) PRINT FULL NAME ELIZA A. McALISTER
3. (b) If veteran, name war ____ 3. (c) Social Security No. ____
4. Sex Female 5. Color or race NEGRO 6. (a) Single, widowed, married, divorced Widow
6. (b) Name of husband or wife Unknown 6. (c) Age of husband or wife if alive ____ years
7. Birth date of deceased Unknown (Month) (Day) (Year)

8. AGE: Years	Months	Days	If less than one day
abt. 69			hr. 1 min.

9. Birthplace Mississippi (City, town, or county) (State or foreign country)
10. Usual occupation House Work
11. Industry or business At Home
FATHER 12. Name Unknown
13. Birthplace Miss. (City, town, or county) (State or foreign country)
MOTHER 14. Maiden name Unknown
15. Birthplace Miss (City, town, or county) (State or foreign country)
16. (a) Informant Wade McAlister
(b) Address 2417 Dickson
17. (a) ____ (Burial, cremation, or removal) (b) Date thereof 3-28-1940 (Month) (Day) (Year)
(c) Place: burial or cremation Washington Park
18. (a) Signature of funeral director Atkins Bros.
(b) Address 3644 Finney Ave
19. (a) MAR 26 1940 (Date received local registrar) (b) J. [illegible] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 22 year 1940 hour 8 a. minute 15 A.M.
21. I hereby certify that I attended the deceased from ____, 19__, to ____, 19__; that I last saw h__ alive on ____, 19__; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Cerebral Hemorrhage	
Due to Arteriosclerosis	
Due to ____	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations ____
Of autopsy ____

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) ____
(b) Date of occurrence ____
(c) Where did injury occur? ____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? ____ (Specify type of place)
While at work ____ (e) Means of injury ____

23. Signature Alfred Henry (M. D. or other)
Address Deputy Coroner Date signed 3-28-40

(Licensed Embalmer's Statement on Reverse Side)

Je 4467

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed Louis V. Attina

Licensed Embalmer No. 2842

P. O. Address 3644 Fi

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wi the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.